The Health of New Hampshire's Community Hospital System

A Financial Analysis

Huggins Hospital




Office of Planning and Research
New Hampshire Department of Health and Human Services
129 Pleasant Street • Concord, New Hampshire 03301
www.dhhs.state.nh.us

An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

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Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[1]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

[1] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[2]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

[2] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire.*

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with $100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

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For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

HUGGINS HOSPITAL, WOLFEBORO, NEW HAMPSHIRE 1993 – 1999 FINANCIAL ANALYSIS

Huggins Hospital in Carroll County is an 82-bed acute-care facility with 27 beds in a nursing-home type unit[3]. As of 1997, Medicare followed by private insurers represented the largest percentage of payers for inpatient discharges (53 and 32%, respectively)[4].

The hospital wholly owns Huggins Senior Housing, Inc., a for-profit company formed to develop and manage Sugar Hill Retirement Community Association, a for-profit retirement community. As of 1998, Sugar Hill was still under construction, with 57 of 114 units completed. Though Huggins Senior Housing is wholly owned by the hospital, it was not consolidated until 1998. For consistency, our analysis uses hospital-only financial data for all six years. The hospital also owns Huggins Charitable Foundation, a nonprofit organization responsible for fundraising, though no activity was reported for this entity from 1993-1998.

Summary of Financial Analysis 1993-98
The financial performance of Huggins Hospital over this period was very strong. Despite recent declines, profit margins were large enough to enable the hospital to rely only on equity sources of capital for its investing requirements and to pay off the small amount of outstanding long-term debt, leaving the hospital with little financial risk. Profitability, liquidity and solvency indicators were extremely healthy and illustrate the hospital's financially advantaged position relative to other hospitals in the state.

Cash Flow Analysis 1993-98
Strong profitability resulted in a very healthy pattern of cash sources and uses over the period. The hospital met all of its investing needs from cash generated by equity sources. Net income generated 70% of the total cash; operating margins were strong enough to represent half of the total cash sources and nonoperating activities generated an additional 18%. However, cash from operating income may be slightly overstated since the hospital did not break out nonoperating from operating activities between 1994 and 1995. Regardless, profitability generated almost three-quarters of the hospital's cash flow over the period, and most of the remaining one quarter was generated was from depreciation.

Cash was used mostly to invest in property, plant and equipment (PP&E) (37% of total cash uses). This investment ($9M) was 45% more than depreciation expense ($6M) over the period, which was adequate to maintain a steady average age of plant throughout the period of roughly 9-10 years.

Close to one-third of the hospital's cash was used to build cash balances – both to increase the cash account (24% of total cash uses) and to invest in marketable securities (11%). As a result, the hospital has built a large amount of liquidity by 1998 – 511 days of unrestricted cash.

In addition to building cash balances, the hospital's strong performance enabled it to use almost one-quarter of its cash providing loans ($6M) to its for-profit subsidiary to fund the development of the nursing home facility.

[3] The 1998 American Hospital Association Guide.
[4] 1997 data from the State of New Hampshire Department of Health and Human Services.

Ratio Analysis 1993-98[5]

Profitability

Profit margins were very strong and increased over the period, reaching a peak of 20% in 1996. Since that time, margins declined but remained strong in 1998 at 13%. Operating profitability drove the total margins, with a relatively high markup of charges over cost that offset payer deductions (deductible). The hospital's markup of price over cost reached 1.91 in 1996, the hospital's most profitable year.

Nonoperating activities bolstered strong income from operations and contributed as much as one-third of the bottom line in recent years. The nature of nonoperating activities could not be determined, as they were not broken out on the income statement or in the footnotes. In fact, nonoperating gains were not segregated from operating profits in 1994 and 1995, which contributes to the jump in operating profitability in these years.

Liquidity

The hospital has a large amount of liquidity, reflecting its ability to increase cash balances. The large cash balances drove the strong trend in the current ratio, which shows that the hospital can meet its current obligations many times over.

Days cash on hand measures illustrate the large cash balances. Short-term cash represents 192 days of operating expenses by 1998. With the inclusion of unrestricted marketable securities, the hospital has 511 days of unrestricted cash by 1998. These large balances give the hospital much flexibility in making strategic choices, and if the hospital is in a competitive situation, it will have strong competitive advantage. (Note: An accounting policy change was adopted in 1996 that required certain investments to be reported at market value rather than historical cost; this affected the change in days cash with all sources between 1995 and 1996.)

Management of working capital improved over the period. The hospital collected its patient accounts faster, decreasing the days in accounts receivable from 75 to 45 days, which provided it with cash to pay vendors faster, as reflected in the decreasing average pay period from 48 to 40 days.

Capital Structure

The hospital has almost no financial risk since large profit margins allow it to rely exclusively on equity sources of capital. The equity financing ratio (equity/total unrestricted assets), which remained at 94% over the period, reflects short-term liabilities used to finance working capital. The hospital has no long-term debt by 1998. This untapped source of capital strengthens the hospital's financially advantaged position.

Charity Care and Community Benefits

Charity care reported as charges forgone represented 1 to 3.8% of gross patient service revenues from 1993 to 1998 and declined over the period. This amount of charity care did not meet the estimated value of the hospital's tax exemption. With the inclusion of 100% bad debt, this benchmark was met in 1994.

The hospital did report Medicaid costs exceeding payment as additional quantifiable community benefits in the footnotes to its financial statements (Medicaid costs exceeding payment are not

[5] NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

allowable under the New Hampshire community benefit statute.) This totaled $2.1M. With this amount added to free care, the hospital met the estimated tax benefits in 1993 and 1994; the hospital did not meet this benchmark in any other years, even with the inclusion of 100% bad debt.

In addition to charity care, the hospital offered HIV/AIDS services[1], which may be considered an additional charitable benefit to the community.

Cash Flow Analysis 1993 - 1999

Net income generated 49% of the total cash. Cash was used mostly to invest in property, plant, and equipment (PP&E) (36% of total cash uses). This investment - $11 million - was 43% more than the $7.8 million depreciation expense over the period. This amount was adequate in the maintenance of a steady average age of the plant throughout a period of roughly 10 years.

Approximately 42% of the hospital's cash was used to build cash balances - both to increase the cash account (27% of total cash uses) and to invest in marketable securities (15%). As a result, the hospital has built a large amount of liquidity by 1999 - 565 days of unrestricted cash.

A $6 million inter-company debt for the development of the nursing home facility was still outstanding.

1999 Ratio Analysis

Profitability

Total margins of 18 percent were very strong. Operating margins of 10 percent were also strong. The hospital's price markup over cost was 1.8 times. The total margin has increased 5% since 1998, and the operating margin has increased by 1%. This is due to net revenue growth at 8% greater than the increase in operating expenses of 7% in 1999.

Non-operating activities bolstered strong income from operations and contributed roughly 50% of the bottom line in 1999.

Liquidity

The current 1999 ratio of 11.54 indicates that the hospital can easily meet its current obligations.

Short-term cash represents 223 days of operating expenses in 1999. With the inclusion of unrestricted marketable securities, the hospital had 566 days of unrestricted cash by 1999. This is well above the 1997 national and regional averages at 110.2 days and 118.8 days respectively. In addition, this cash position is also well above the 75th percentile in New Hampshire of 348 days in 1999.

The hospital collected its patient accounts more slowly in 1999 than in 1998, increasing the days in accounts receivable from 45 to 56 days. The hospital also increased its accounts payable days from 39 to 43 days to maintain its current ratio.

Capital Structure

The hospital has almost no financial risk since large profit margins allow it to rely exclusively on equity sources of capital. The equity financing ratio (equity/total unrestricted assets), remained at 94% in 1999. The hospital has no long-term debt. This excess debt capacity strengthens the hospital's financially advantageous position.

Charity Care and Community Benefits

Charity care reported as charges forgone represented 0.8% of gross patient service revenues in 1999. This represents a reduction from 1.22% in 1998 to 0.8% of GPSR in 1999. The bad debt charges to gross patient service revenue have increased slightly from 3.16% in 1998 to 3.63% in 1999.

The hospital established a not-for-profit Huggins Charitable Foundation for the purpose of raising funds to increase the level and quality of health care in Wolfeboro. The Foundation had no activity during the period ending September 30, 1999.

Summary

The hospital's financial position was very strong in 1999. It not only has strong operating margins; it also has a high level of investment ($24 million in both long-term and short-term investments). In addition, the hospital does not have any long-term debt.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health